"On Sounding the Frontal Sinus," by Dr. Jurasz (*Berliner klin. Wochenschrift*, No. 3, 1887). The probe is introduced from the nose. The utility of the procedure is not evident.

"Vesical Fistula after a Radical Operation for Hernia," by Dr. Feilchenfeld (*Berliner klin. Wochenschrift*, No. 3, 1887). Male, aged fifty-one; scrotal hernia. Removal of sac with ligature of neck. Urinary fistula formed at wound, which closed after many weeks. The author supposes that a vesical diverticulum must have been engaged in the ring.

"The Classification of Tumors of the Testicle," by Drs. Monod and Arthaud (*Revue de Chirurgie*, March 10, 1887).

"Malformations of the Anus," by Dr. Jeannel (*Revue de Chirurgie*, March and April, 1887).

IN AMERICA.

REMOVAL OF A LARGE SARCOMA, CAUSING HEMIANOPSIA, FROM THE OCCIPITAL LOBE.

DRS. W. R. BIRDSALL and ROBERT F. WEIR (*The Medical News*, April 16, 1887) make a most important contribution to brain surgery; among other points demonstrating that hemorrhage must be primarily arrested in operations involving the brain structure by reliable methods, such as the ligature, torsion, or prolonged forcipressure, and not by the tampon.

A man, æt. forty-two, in August, 1885, suddenly noticed unsteadiness of gait, succeeded by a violent attack of vomiting. Diplopia for distance soon appeared, with increasing muscular incoördination; numb sensations of the right arm, leg, and shoulder; but no disorder of sensation of the face. All these symptoms were intermittent. Occasional moderate frontal headache was experienced. No vertigo was noticed at first, and no other sensory, motor, or visceral symptoms appeared. Hemianopsia, was detected, with incipient neuro-retinitis. The diagnosis was, "tumor of mesial aspect of right occipital lobe, involving primarily the cuneus, extending downward toward the tentorium cerebelli, and perhaps also upward toward the paracentral lobule (leg centre)." Slight improvement in gait, under the use of iodide of potassium, was observed until as late as July, 1886; but in September the muscular incoördination and occasional drowsiness rapidly increased.

Examination now showed the left lateral hemianopsia still present; the neuritis well advanced, although more marked in the left eye; irides active, both to light and accommodation—the left pupil larger than the right; no diplopia, no "ocular paresis;" the special senses were normal, and there was neither anæsthesia, analgesia, disturbance of the temperature sense, paresis, nor tremor of the muscles; and the motions were "clumsy," rather than ataxic—"uncertainty of control" seemed the best term for it; and the disturbance of equilibrium increased in a most irregular manner.

On March 9, 1887, Dr. Weir operated antiseptically. An oval opening, two and three-quarters by two and one-quarter inches, was made through the bone by means of a trephine and the rongeur. The non-pulsatile dura mater was opened for two-thirds of the extent of the bone wound, and the tumor, of a purplish-red color, presented at once, covered by a thin cellular layer containing large ramifying veins. By means of a director and spoon-handle, a thin layer of brain substance was loosened from its outer side, and by a continuance of these proceedings the growth was readily separated at the sides; but even after further free removal of bone tissue, the outlying edges and base of the growth could not be reached until it was incised and its softened interior squeezed out. After this, separation was readily effected by the finger-nail until the base was reached, when the growth was nearly torn in half, its outer portion lifted out, separated from the falx, and the whole mass withdrawn. Considerable venous oozing occurred, but was readily arrested by sponge pressure. Two bleeding points were seen: one venous, in the region of the straight sinus; and the other arterial, possibly a terminal branch of the posterior cerebral artery. Moderately firm packing with iodoform gauze to check bleeding, partial suture of the dura mater and scalp, with a careful antiseptic dressing, completed the operation. Some failure of the pulse was observed when the growth was being lifted out, probably due to loss of blood—in all, computed to be from f℥x to f℥xij—but hypodermatics of whiskey relieved this condition.

After the rapid recovery from the anæsthetic, slight divergent squint of the left eye was noted; the pulse was 132, regular, and of good volume. Enemata of milk punch were ordered every two hours. Two hours after operation the pulse was 120, weak, and there was much blood-staining of the dressings.

At 10 P. M. the patient was very restless, with an extremely weak pulse, and steady bleeding was evidently going on. Two quarts of salt solution, as modified by Landerer, were slowly injected into the median basilic vein with immediate improvement in the pulse and consciousness. Slight paralysis of the ocular branch of the seventh nerve was now detected, in addition to the already noted divergent squint on the left side. Hemorrhage being evidently the cause of the unfavorable symptoms, the dressings were removed, but such free bleeding occurred as to forbid anything more than the application of an additional iodoform gauze tampon, and a second transfusion was made; but, despite everything, death occurred at 2 A. M.

Dr. Weir regrets that forcipressure forceps, allowed to remain for from twenty-four to forty-eight hours, with elevation of head, had not been resorted to at the outset. The advisability and dangers of free bone openings are discussed, bone-grafting is advocated, either by dusting the finely minced bone over the dura mater, or by replacement of the trephine disks.

This case makes the eighth operated on for brain tumor. In five instances the growth was found and removed; in one, partial removal was effected; and in the remaining two, no tumor was found, although in one case the postmortem, two and a half months later, revealed a growth pressing upon the cerebellum and spinal cord.

The growth weighed 5¼ ounces, and measured 3¼ inches by 2¾ by 2½ inches thick, the greater circumference measuring 8½ inches.

PLEUROTOMY BY RESECTION OF THE RIBS FOR EMPYEMA.

DR. W. H. STRICKLER (*The Medical News*, May 7, 1887) describes the following operation: Across the sixth rib in the axillary region a vertical cut of three inches is made with its centre over the rib. A transverse cut of one inch crosses the primary one at its centre. The sixth rib is bared, partially divided at two points by a Hey's saw, and finally severed by bone forceps. The pleura now being opened the chest is explored by the finger to ascertain the position of the diaphragm, when a section of the seventh and of the fifth ribs is removed—about one inch of these, while the exsected portion of the sixth rib measures one and a half inches; this is to secure space between the extremities of the segments of this rib, when the cut ends of the fifth and seventh ribs are driven together by atmospheric pressure. All bone sections having been completed, the pleural cavity is carefully explored, by the whole hand, except the thumb, all fibrinous masses are carefully removed, any bands likely to prevent expansion of the lung ruptured, and the cavity thoroughly irrigated with large quantities of hot water. All but the centre of the wound is sutured, and gauze and oakum applied over all. After the first week a tube is used to keep the wound patent, which is gradually reduced in size. From the outset, daily flushings with hot water are used. Five cases are reported, which have done well. The operation is a modification of one in general use.

Pistolshot Wound of the Abdomen; Laparotomy; Nephrectomy; Autopsy.

Dr. W. W. Keen (*The Medical News*, May 14, 1887) gives the details of a most interesting case, which should be carefully studied by every surgeon, illustrating, as it does, many points which are both new and of practical importance in this latest field of operative surgery. The title contains nearly all the essential points, and since nothing short of an almost complete reproduction of the paper could do it justice, we shall merely add what seems to be the apparent cause of the fatal termination of a case which bade fair to recover, and one or two minor points worthy of comment. Generalized, non-suppurative peritonitis was found post-mortem, and a gangrenous portion of bowel opposite to the ball wound of the intestine, in the centre of the dead portion two perforations existing with pus in the lumen of the bowel. This was probably the cause of the peritonitis, and Dr. Keen thinks resulted from contusion of the mesentery not detectable at the operation, but causing thrombosis of the arterial supply to the portion of bowel-wall which necrosed. An extensive intermesenteric layer of blood effused before, and found at the operation, had also broken down and looked purulent, but did not communicate with the peritoneal cavity. At the post-mortem examination the right kidney was found to have undergone marked compensatory enlargement, which the clinical history indicated must have taken place, since the urine, while scanty at first, gradually increased in three days from ℥iij of albuminous fluid to ℥xl of normal secretion.

Splenectomy for Wandering Spleen.

Dr. W. H. Myers reports (*Journal of the American Medical Association*, April 2, 1887) a successful case, the operation being demanded for the relief of septic symptoms induced by abscess, resulting apparently from the pressure of an enlarged and dislocated spleen. The suppuration was unquestionably favored by the post-partum state, the patient having been delivered about three weeks previously, although the splenic hypertrophy had existed to a marked degree for over one year. The perisplenic abscess had opened externally before operation by three orifices. Strict antisepsis was attempted and secured. The pedicle was transfixed by a double ligature, tied in halves, and dropped into the cavity, and a glass drainage tube inserted. The tumor weighed seven pounds. Recovery was prompt, the patient going home on the twenty-first day.

ANEURISMS TREATED BY THE INTRODUCTION OF CATGUT OR OF WIRE, WITH ELECTRICITY.

In this most interesting paper (*The Medical News*, April 9, 1887) DR. ROBERT ABBE reviews the histories of those cases treated by wire alone, and then relates an instance in his own practice, where the introduction of one hundred feet of aseptic No. 1 catgut into the cavity of a large dissecting aneurism of the right subclavian artery was of temporary benefit. Increase in size occurring after a few days, one hundred and fifty feet of fine sterilized steel wire were introduced through an insulated aspirator needle, the positive pole of a galvano-faradic battery was attached to the extremity of the wire, while a copper plate—12 inches by 12 inches—covered with wet cotton, placed over the back, was connected with the negative pole. A current of fifty milliampères was at first used, finally a very much stronger current, the current being reversed during the latter part of the operation, which occupied one hour. For twenty-four hours decided hardening of the tumor was noted, then it rapidly increased, death resulting on the second evening from rupture into the trachea.

The writer reviews the results of this, and similar treatment, in the practice of others, concludes that, as it has only been tried in desperate cases, we are not able to decide what value inheres to the practice, and thinks that, as it does no harm, it should be still tried—all the more, as the post-mortem results show that in many cases large quantities of firm, laminated clot have been formed, while "the subsequent much-desired inflammation of the sac was easily kept under control by ice-bags in every case." Two cures have resulted from the introduction of wire, while electrolysis alone has occasionally succeeded. In reality, Dr. Abbe has combined both methods—*i. e.*, introducing a tangled mass of easily compressible wire reaching every portion of the sac, and then inducing deposition of clot upon it by electrolysis; in addition, inflammation of the sac, which Cinicelli contends is essential to the success of his method, is induced.

A CASE OF INNOMINATE ANEURISM TREATED BY SIMULTANEOUS DISTAL LIGATION OF THE RIGHT CAROTID AND SUBCLAVIAN ARTERIES. RECOVERY.

DR. H. R. WHARTON records (*The Medical News*, April 9, 1887) the history and results of treatment of a case operated upon by Professor J. Ashhurst, Jr., at the University College Hospital, on November 13, 1886. The right common carotid was ligatured with catgut above the omohyoid muscle, after which the subclavian of the same side was secured just outside the anterior scalene muscle. Silver sutures, drainage tubes, and an oiled lint dressing were used. Neither unpleasant cerebral symptoms occurred, nor did improvement in the aneurism at first take place. In a few days, however, the aneurismal tumor became smaller, the dyspnœa and dysphagia markedly diminished, and the patient could sleep in the recumbent posture. No radial pulse was detectable even when discharged two months after operation. Examination at that time showed only the merest traces of the previous trouble, so slight, indeed as to warrant the belief that a complete cure has resulted. The recorded cases of this operation are examined and commented upon, the results of consecutive ligation compared, and the opinion expressed that the simultaneous ligation of the right carotid and subclavian arteries for innominate aneurism "is a more efficient and safer procedure than consecutive ligation of these vessels."

THREE CASES OF LIGATURE OF THE EXTERNAL CAROTID ARTERY, IN TWO OF WHICH BOTH VESSELS WERE TIED SIMULTANEOUSLY.

DR. JOS. D. BRYANT (*The Medical News*, May 14, 1887), in a lengthy paper, well worthy of a careful perusal, sums up with the following conclusions: 1. Ligature of the external carotid artery, together with independent ligature of the branches arising from the first inch of its course, is a safe and commendable operation. 2. When the facial and lingual arteries do not arise singly, or by a common trunk, from the first inch of the course of the external carotid, the branches arising at the point of bifurcation of the common carotid should be tied. 3. Simultaneous ligature of both external carotids is a rational preparatory measure for operations involving the parts supplied by their branches when dangerous hemorrhage is feared. If the pharynx be involved, the ascending pharyngeal branches should be ligatured also. 4. Simultaneous ligature is advisable as a final expedient to diminish the rapidity of the development of extensive, malignant growths when they are nourished by the branches of the external carotids. 5. Ligature of one or both external carotids for the cure of aneurismal formations of the branches of the same is not feasible as an independent curative measure. 6. Ligature of the common carotid should not be done for the cure or for the arrest of morbid conditions involving the external carotid or its branches, except as a final resort.

THE TREATMENT OF OLD DISLOCATIONS OF THE ELBOW.

DR. L. A. STIMSON reports, in *The Medical News* for April 2, 1887, a case in which arthrotomy was resorted to, and upon the reproduction of the displacement, excision of the joint was done two months after the first operation.

Attention is called to the adhesions formed by the remains of the lateral ligaments and adventitious cicatricial bands between the olecranon and humerus, which take place so far up and behind the centre of motion that reduction can only be effected by a greater degree of force than originally produced rupture of the articular ligaments. Stripping up of the periosteum on the dorsum of the humerus by the head of the radius occasionally takes place, with a consequent formation of bone greatly interfering with reduction. Removal of pressure from a growing epiphysis—*i. e.*, that of the capitellum of the humerus—may result in an overgrowth of this process in the young, while elongation of the neck of the radius may take place from the same cause, both of these conditions preventing reduction. Fractures of portions of the coronoid process, the head of the radius, or of the epitrochlea, may, by subsequent bony adhesions in new sites, present insuperable obstacles to replacement of the articular surfaces.

Stimson, in his arthrotomy, made a single, instead of the usual bilateral incision—which latter procedure he announces he intends adopting in the future—divided the olecranon, separated adhesions, reduced the luxation, and then sutured the divided bones with silkworm gut. Owing to the strain exercised upon the olecranon by the tense triceps muscle, the elbow had to be fixed at an angle of 145 degrees, a position which doubtless determined the redisplacement.

Dr. Stimson concludes by stating his acceptance of the rules formulated by Albert for cases of old backward luxation of the elbow, viz., rupture or tenotomize adhesions in the elderly, and if reduction then fails, forcibly flex the elbow to a right angle, with or without fracture of the olecranon, and allow ankylosis to occur. In younger subjects divide subcutaneously all bands, and even the triceps, to avoid fracture of the olecranon; but if the bones cannot then be replaced, arthrotomy should be done by two lateral incisions. Finally, if everything fail, excise the joint.

OPHTHALMOLOGY.

UNDER THE CHARGE OF

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OPHTHALMOPLEGIA EXTERNA ACUTA.

In the *Edinburgh Medical Journal* for March DRS. BERRY and BRAMWELL report a case of ophthalmoplegia externa acuta in a child of two and a half years, probably due to a scrofulous lesion of the pons Varolii, with subsequent recovery. The authors admit that the exact nature of the lesion must, to some extent, be a matter of conjecture, but were disposed to think that it was probably tubercular from the sudden nature of the attack and the clinical history of the case. The ocular symptoms manifested themselves as follows: Almost complete ptosis of both lids, inability to elevate the eyes, complete loss of the power of depressing them; the internal rectus of the right eye was absolutely, and that of the left almost completely, paralyzed; absolute divergence of the eyeballs, the pupils from four to five mm. in diameter, which contracted promptly to light. There were no visible changes of the fundus oculi. Dr. Berry's diagnosis was paralysis of the third and fourth nerves and paresis of the sixth—*i, e.*, almost complete ophthalmoplegia externa.

By careful examination, no loss of sensation or derangement of motion could be elicited other than could be accounted for by the general apathetic and drowsy condition of the patient. The authors localized the lesion at the top of the pons Varolii and in the neighborhood of the aqueduct of Sylvius, from the fact that the muscles supplied by the third, fourth, and sixth nerves on both sides were involved and vision unaffected. The prompt pupillary